Appendix 2 - Overview of Health and Social Care Integration

Our principle	Our objectives for integration	Our measures
We will shift our services from being paternalistic to ensuring that services are designed for and with the people who use them.	People will be involved in the redesign of integrated services	• Patients and service users will be involved in pathway reviews, service specifications and tendering.
Care will be as close to home as possible, with home always as the first option **We will focus care around the person, building up from communities of approximately 20,000 people** **We will join up care at a local level and will work with communities to integrate care around clusters of GP practices and other community settings**	We will create multi-disciplinary teams, wrapped around primary care clusters, providing integrated, accessible care in local communities. These teams will work across community health services, social care, mental health, voluntary sector, commissioned Help to Live at Home providers and other community resources such as sheltered housing. Services will match levels of needs in each community and existing inequalities in levels of service provision in some parts of the county will be levelled out.	• Emergency attendances and admissions to acute hospitals will not increase • Long-term care home admissions will be reduced • Activity levels of community health services will increase • Patient and customer experiences of services will improve
We will ensure that care is coordinated for all older people, particularly to support those at risk of deterioration and hospital admission.	We will create a team around the person, with someone to coordinate care between all professionals and agencies involved, so that people at the receiving end feel in control.	• Emergency attendances and admissions to acute hospitals will not increase • Every older person will have a named GP and a coordinated support plan • It will be possible to share information between professionals so that care is more effective, more timely and more safe
We will build on the council's work with local communities on the development of campuses	Within the next 5 years, we will see accessible locations within communities bringing together services such as primary and community health with leisure, library and other council services and the voluntary sector. Facilities can be used imaginatively as a resource to promote health and wellbeing and provide treatment.	• Patient and customer experiences of services will improve.
We will support individuals and communities to take more personal responsibility for their own	We will focus our investment in voluntary and community services, working towards a shift in investment towards	• Reliance on urgent and crisis services will reduce. • Patient and customer

health and wellbeing	more preventative services and more accessible information and advice to promote self-care and independence	experiences of services will improve – people will feel more in control of their care
We will ensure that carers are supported	We will continue to use our carer's pooled budget to provide options for carers and we will plan for new responsibilities to carers under the Care and Support Bill. We will offer carers personal budgets to allow them more choice and control over their support	• Carers' experiences of services will improve
More people will be supported to remain independent	We will develop our intermediate care services to prevent hospital admission and provide a 'stepping stone' for people recovering from a hospital stay. Intermediate care for people with mental health and dementia needs will be strengthened We will seek to implement a system wide approach to Discharge to Assess	• Delayed transfers of care will be reduced • Emergency attendances and admissions to acute hospitals will not increase • Decisions about long term care will not be taken in hospital and admissions to long term care will be reduced • Activity levels of community health services will increase
We will ensure that people have access to the right support when they need it.	People with complex health conditions, including dementia, often need support in the middle of the night or at weekends, and we believe community health and support services should be available 24/7	• People will access new out-of-hours services and unnecessary admissions to acute hospitals will be avoided
We will take a holistic approach, with locally accessible services to support mental health needs	We will integrate mental health and dementia care into our local services and we will support communities to be dementia friendly. We will seek to provide specialist care in community settings We will improve the joint management of the patient s across acute and community care.	• Long-term care home admissions will be reduced for people with dementia • People with mental health needs will not be delayed in hospital
We will ensure that people with dementia can remain independent and living at home for as long as possible within supportive communities.		• A toolkit for dementia friendly communities will be available for Area Boards to use • A Neighbourhood Return scheme will be trialled to support people with memory problems who go missing

People with dementia will be diagnosed early, so that the most appropriate treatment and support is provided to maintain independence		• Diagnosis of dementia within primary care will increase
We will continue to develop outcomes-focussed commissioning, based on our Help to Live at Home model of commissioning	We will commission service providers, including care homes, to focus on outcomes for individuals, in order to give people the maximum independence and choice.	• Care providers will work to contracts with incentives to deliver the best outcomes for individuals • This will reduce the reliance on both acute and community beds
We will reduce duplication of assessments and support plans	We will develop shared assessments and support plans, with appropriate information-sharing systems, and support plans owned by the individuals that they support. We will develop our IT systems	• The number of people with their own single support plan will increase • Patients and customers will say they are be better informed about services
We will minimise delays, with a focus on reducing high numbers of delayed transfers of care across the system	We will review processes for discharge from hospital to minimise delays. The Improvement plan for DTOCs will be overseen by the Integration Director as part of the Better Care Programme We will invest in capacity planning and in 'surge' capacity for community-based services so that our services can better cope when demand is greatest. We will put in place system wide solutions such as the Discharge to Assess programme with home as the default once patient is medically stable We will develop a culture of '7-day discharge'	• The number of delayed transfers of care will be reduced •
We will invest in the capacity and competency of the health and care workforce	We will increase the capacity of the community-based workforce, and ensure they have the skills to support people with complex needs. We will develop a skills	• The objectives of our workforce plan will be met, including increased competencies, improved recruitment and retention of care and support staff.

	academy approach to model and address the supply challenge we are facing. We are benefitting from a systems leadership review which will inform the type of skills, competencies and leadership model we seek to develop in the future.	• The workforce will say they feel valued • The domiciliary care workforce will have a structured career path and zero hour contracts will be minimised